North Dakota EHR Incentive Payment Program

Eligible Professionals

User Guide – Adopt, Implement, Upgrade (AIU)

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Table of Contents

North Dakota Medicaid EHR Incentive Payment Program

Adopt Implement Upgrade (AIU) Attestation for Eligible Professionals

***NOTE – All EPs must first be registered with the CMS EHR Registration and Attestation System at:**

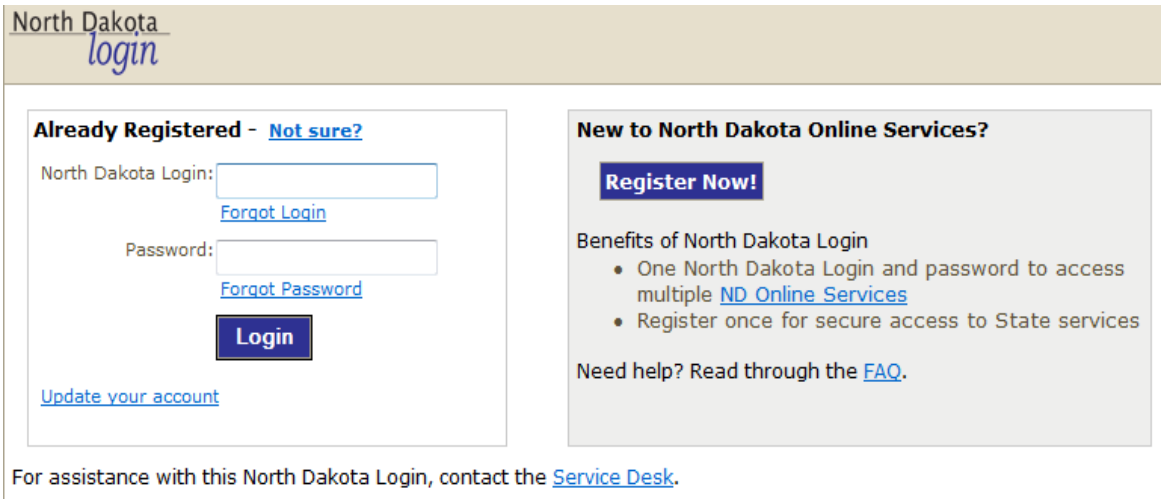
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/RegistrationandAttestation.html

Each EP will receive a CMS EHR Confirmation number that will be needed to start the ND attestation. Please allow 24 hours after registering with CMS for the number to be valid in the ND Portal.

Access ND Registration and Attestation Portal

https://apps.nd.gov/dhs/mmis/hitech/login.htm

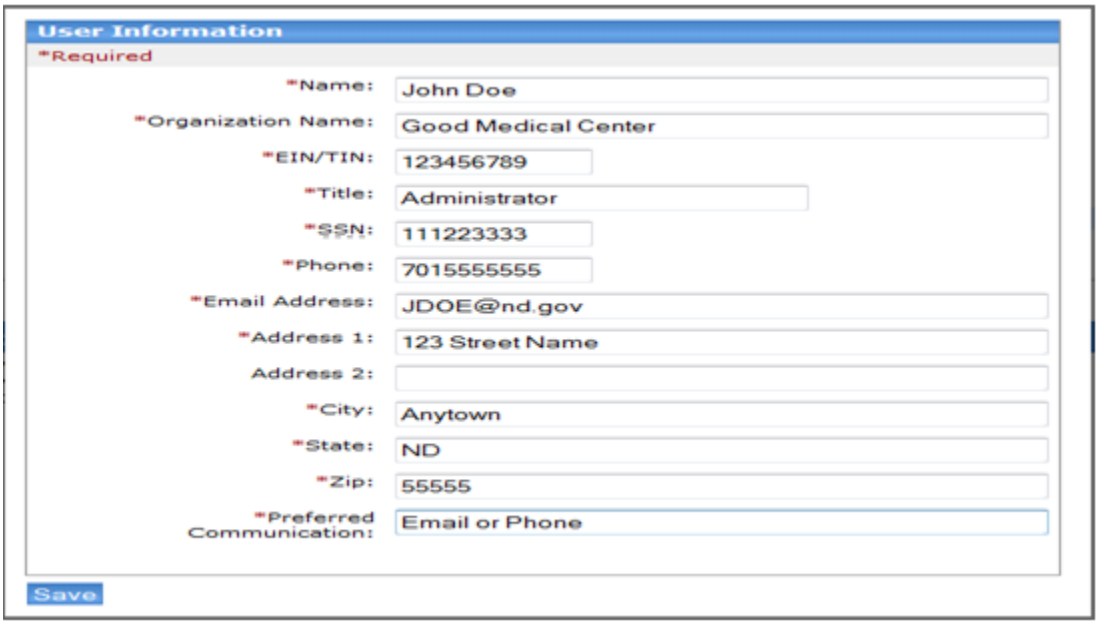
Login – Enter the login information – Refer to the account creation document if you have not created a User ID and Password



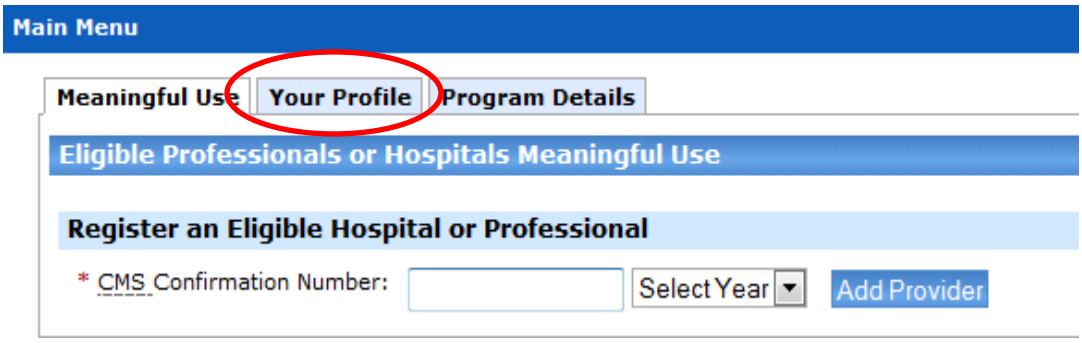
User Profile

The first time a user logs in, a profile must be completed

This should be the person that is attesting on behalf of a provider or the provider if they are self-attesting



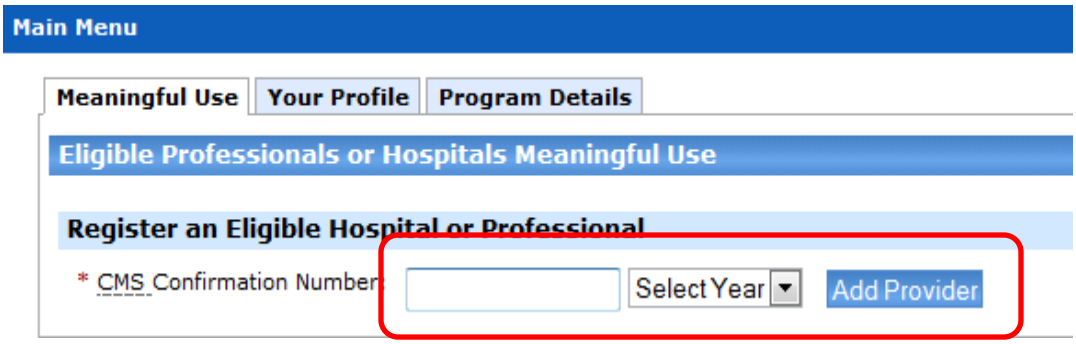
To edit this information at any time, you can access this information from the "Your Profile" tab on the main menu.



Add an EP to the profile

*** If attesting as a group of EP's using the Group Proxy patient volume method, all EPs must be added to the profile before proceeding.**

Enter the CMS confirmation number that was issued when the provider was registered for the incentive program with CMS and select the attestation year for each EP that will be attesting.

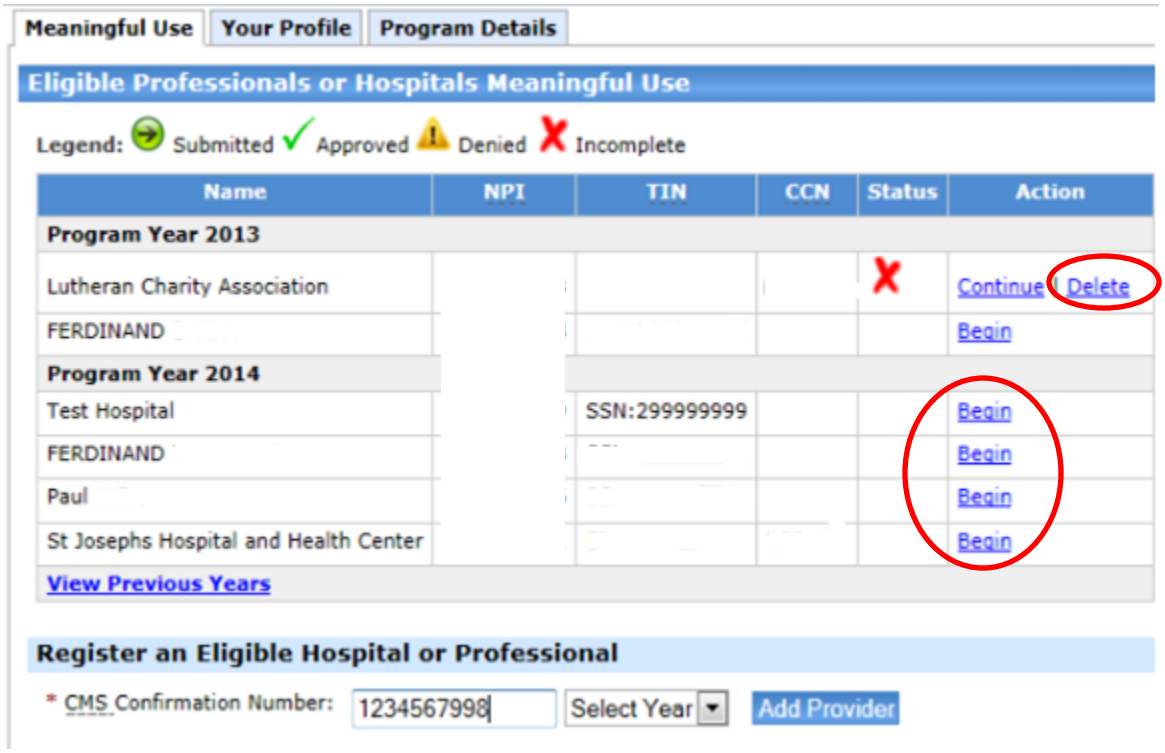


Once all the providers are added to the profile, you are ready to begin the attestation process.

Attestation Process

Patient Volume

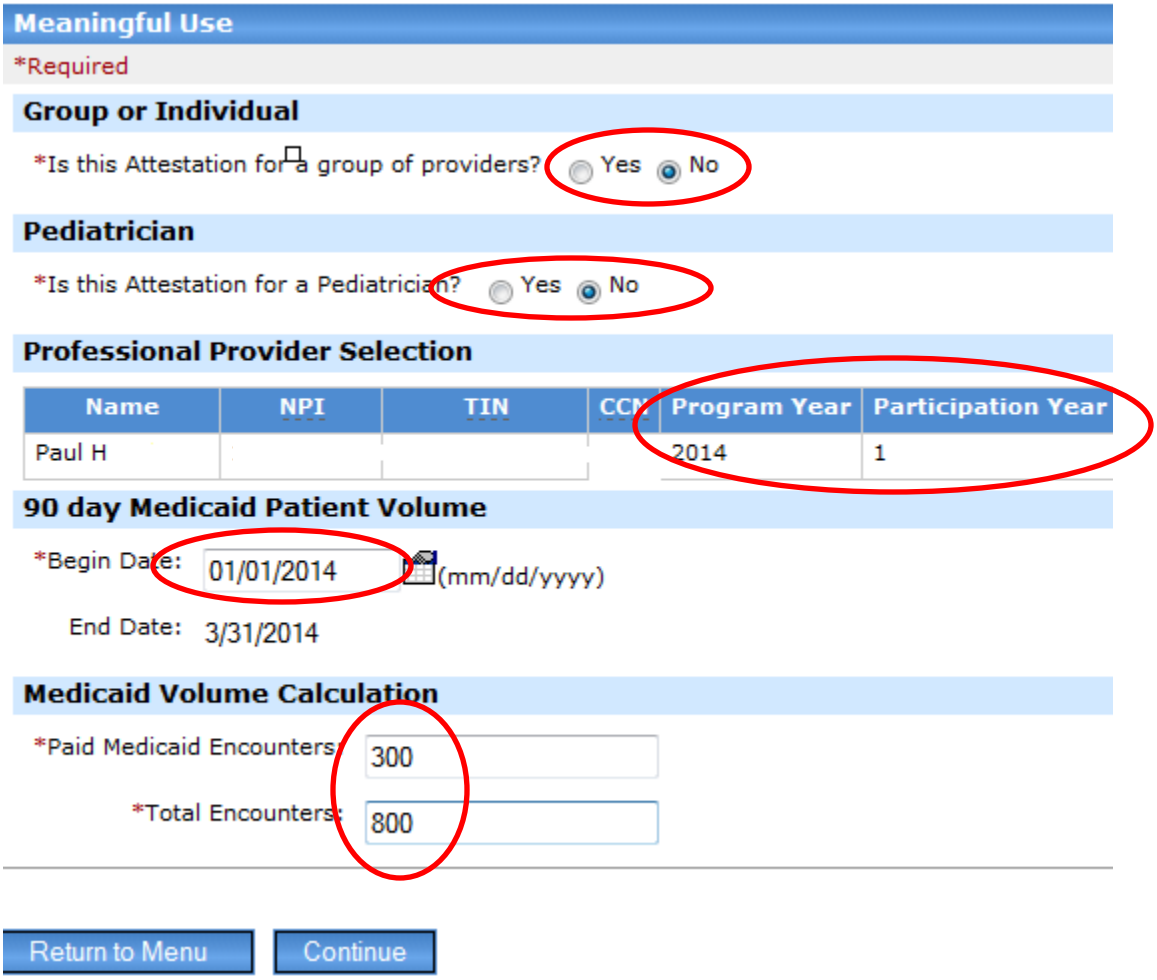
1. Under Action, Click Begin or Continue if you have previously started an attestation.
   Delete will clear all information that was previously entered.
   The Status column will indicate the status of the attestation.



2. For EP's attesting individually, answer the group question as NO. If the attestation is for a group of providers, refer to the Group Proxy user guide
3. If the EP is a Pediatrician, select Yes to the Pediatrician question
4. The Professional Provider Selection will indicate who the attestation is for, the program year, and the participation year.
5. Enter the Begin Date for the 90 day Patient Volume (the system will calculate the end date)
6. Enter the Medicaid Encounters and Total Encounters for the EP

   Medicaid Encounters = All encounters the EP had that were from patients that were enrolled with Medicaid at the time of the encounter

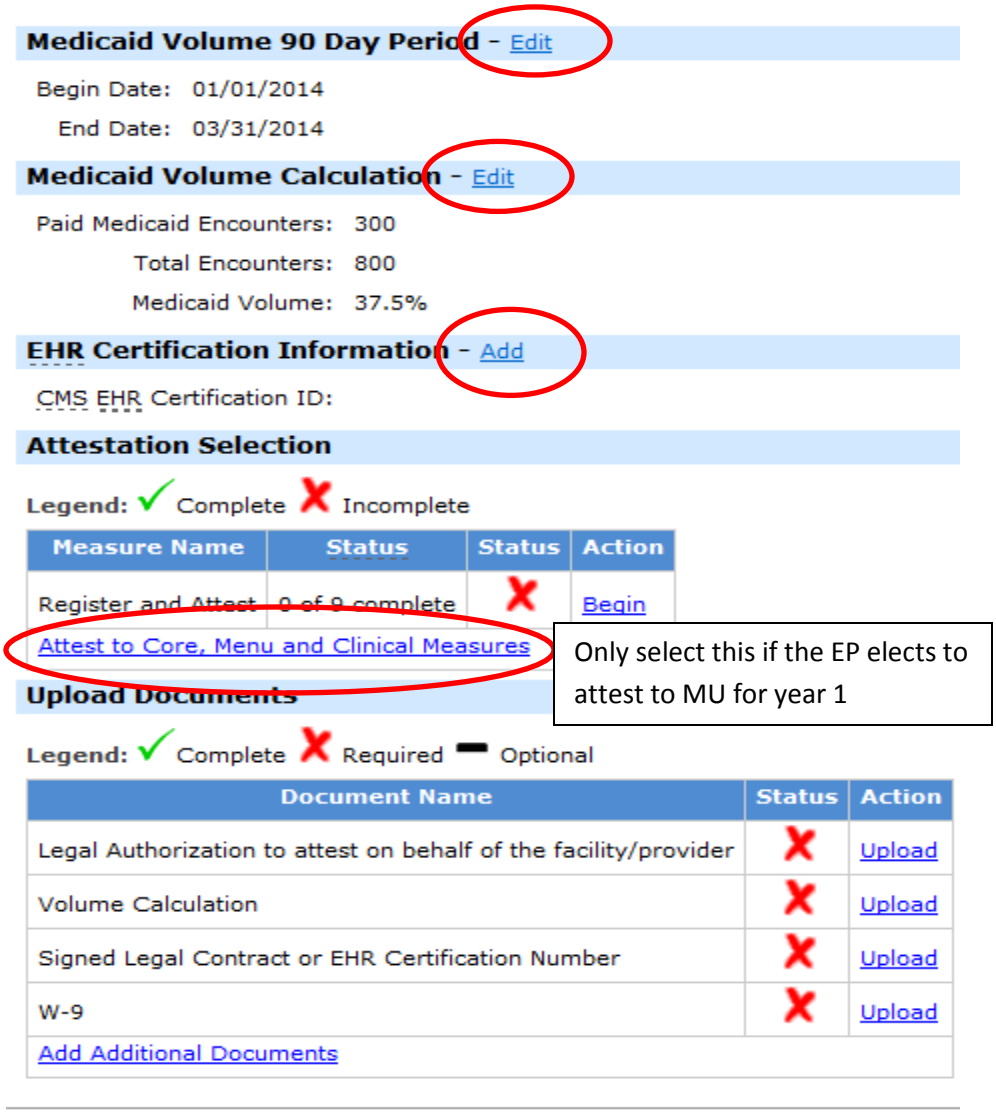
   Total Encounters = All patients encounters during the 90 day period. Medicaid Encounters + Non-Medicaid encounters



7. Continue navigates to the AIU/MU section, Return to Menu navigates to the main menu

AIU – Year 1 only

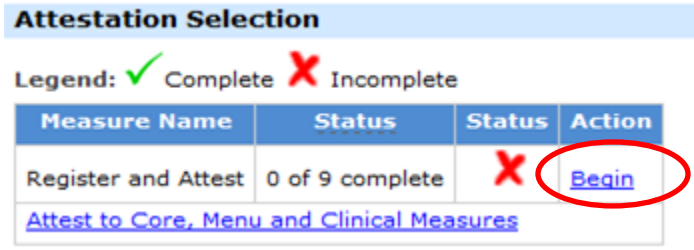
The only information required for AIU is the Register and Attest questions and the required documents. *If the provider elects to attest to Meaningful Use in Year 1, select the link to attest to Core, Menu, and Clinical Measures.



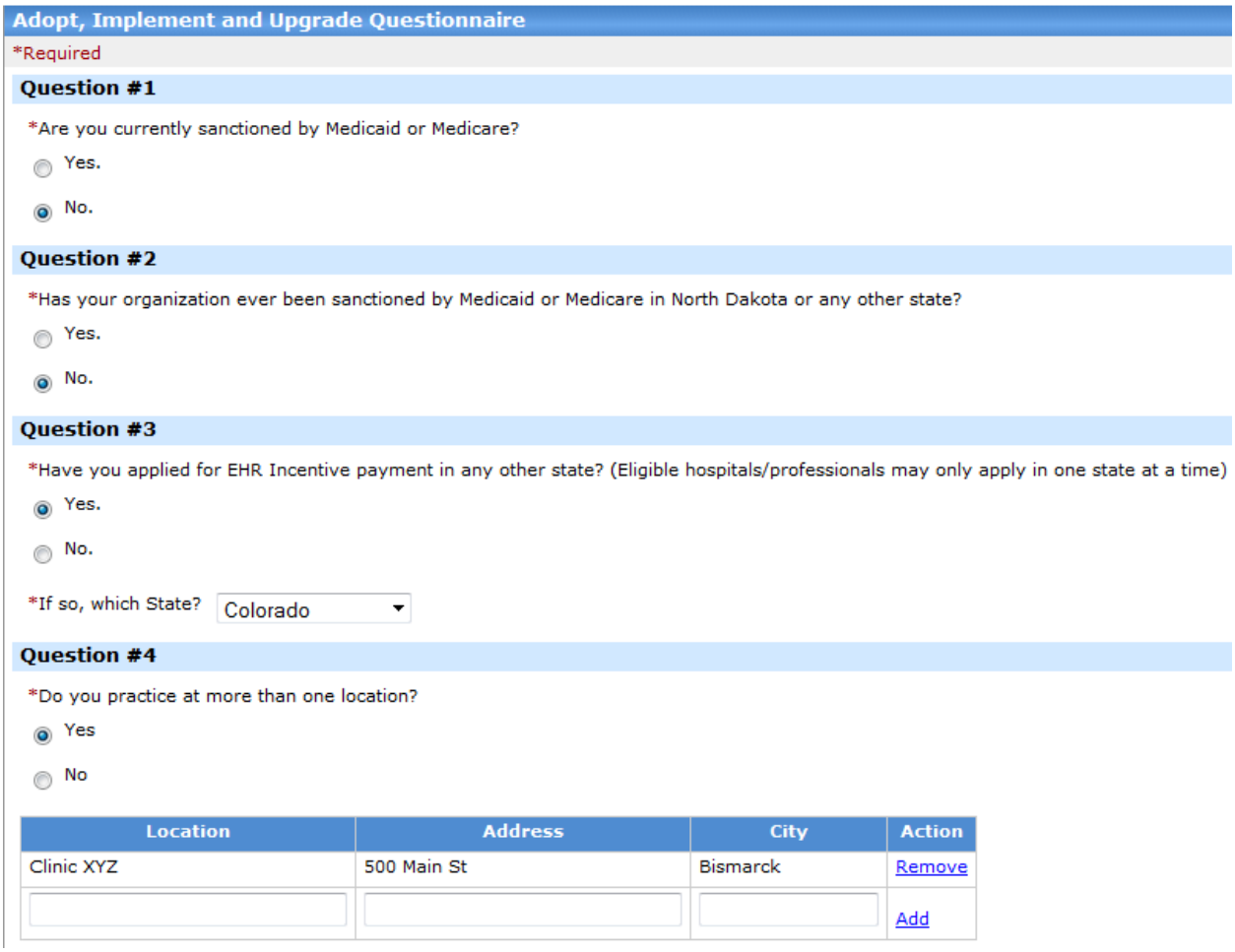
1. To edit/change the Medicaid Volume 90 Day Period or Medicaid Volume, click the Edit link
2. Enter the EHR Certification ID by selecting Add. To obtain the EHR Certification Number, enter the EHR information at the ONC CHPL site: http://oncchpl.force.com/ehrcert/CHPLHome
3. If you are in Year 1 and you would like to attest to MU rather than AIU, select the Attest to Core, Menu, and Clinical Measures link to add the MU criteria.

Register and Attest Questions

4. To Attest to AIU, select Begin to Register and Attest



5. Answer the following questions. These will all be verified before payment is issued. If the provider is found to be sanctioned, been paid by Medicare or by another state, or hospital based, the provider will be deemed ineligible.
   5.1. Q1 Are you currently sanctioned by Medicaid or Medicare? Yes or No
   5.2. Q2 Have you ever been sanctioned by Medicare or Medicaid? Yes or No
   5.3. Q3 Have you applied for an EHR Incentive Payment in any other state? Yes or No, If yes, select the other state
   5.4. Q4 Do you practice at more than one location ➔ If yes, list all other Clinics/Facilities



5.5. Q5 Have you adopted, implemented, or upgraded using a certified EHR ➔ If Yes, select either Adopt, Implement or Upgrade

5.6. Q6 Are you non-Hospital based? ➔ If 90% or more of the EPs encounters are hospital based (POS 21 or 23), the EP is not eligible for payment

Question #5

*Have you adopted, implemented, or upgraded using a certified EHR technology?

- (•) Yes
- ( ) No

*If so, which one?

- (•) Adopt
- ( ) Implement
- ( ) Upgrade

Question #6

*Are you non-hospital based (90% or more of your encounters are NOT performed in an inpatient setting (site of service code 21) or in the emergency department (site of service code 23)?

- (•) Yes
- ( ) No

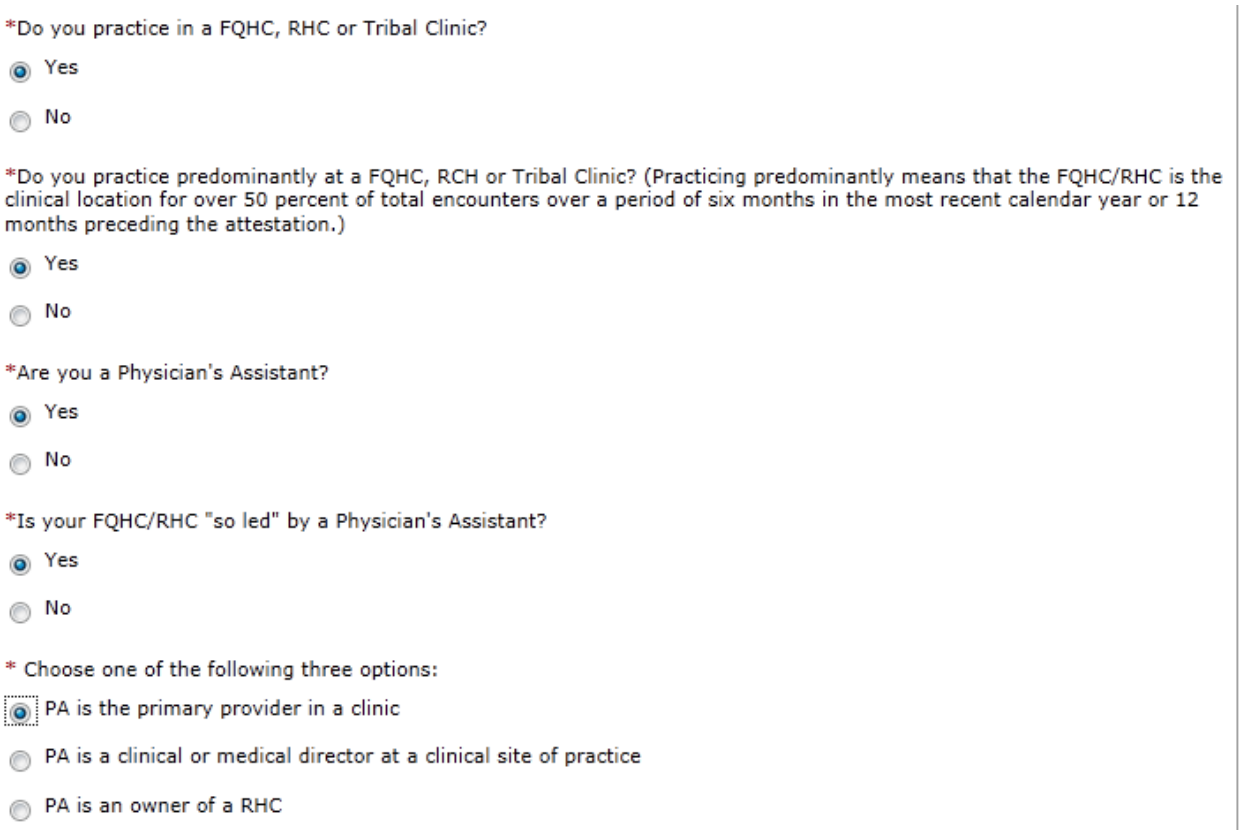
5.7. Q7 Do you practice in an FQHC, RHC, or Tribal Clinic ➔ If yes, are you a Physician's Assistant ➔ If yes, select the qualifying PA requirement (The facility **must** by PA led for a PA to be eligible). The facility is considered PA led if:

5.7.1. The PA is the primary provider in a clinic (part time physician and full time PA)

5.7.2. The PA is the clinical or medical director at a clinical site of practice

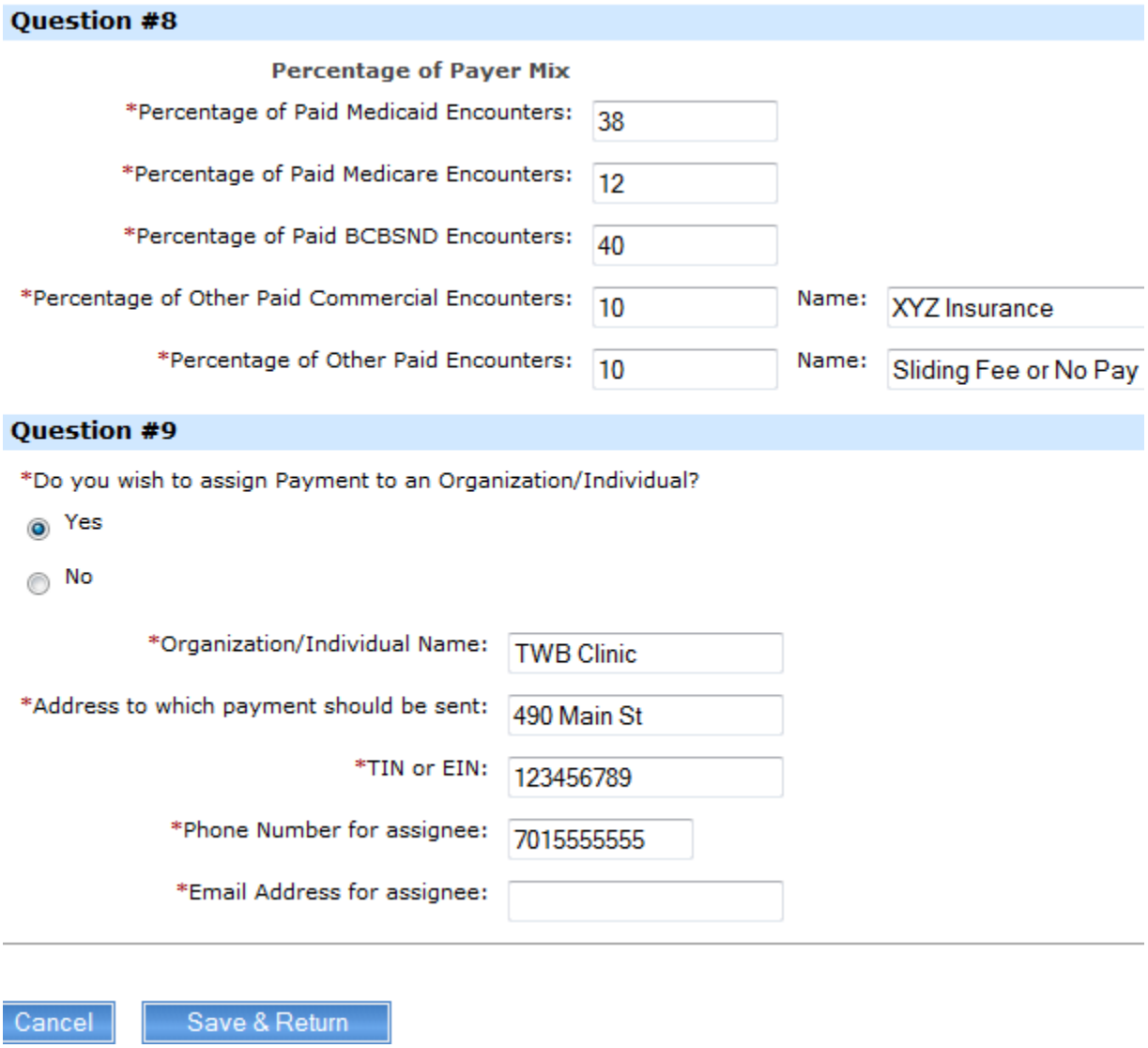
5.7.3. The PA is the owner of the RHC

** If you practice in an FQHC, RHC, or Tribal Clinic, the EP must practice predominately at the facility ➔ Meaning 50% or greater of all encounters must be performed at the FQHC, RHC, or Tribal Clinic and been practicing at the facility for 6 consecutive months



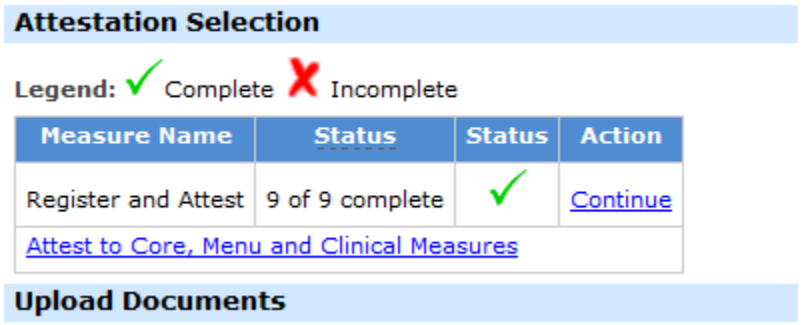
5.8. Q8 Percentage of Payer Mix ➔ This should be from the same 90 day period used for the patient volume, so Percentage of Medicaid should = the same percentage used for patient volume

5.9. Do you wish to assign Payment to an Organization/Individual ➔ If yes, enter the information to whom that payment should be made. A Signed letter of acknowledgement/intent is required from the EP stating they agree payment can be assigned to the facility.



**Select Save & Return to complete the section

6. If the section was completed, the status will indicate with a green check mark, if not, a red X will display indicating it is incomplete



Required Documents

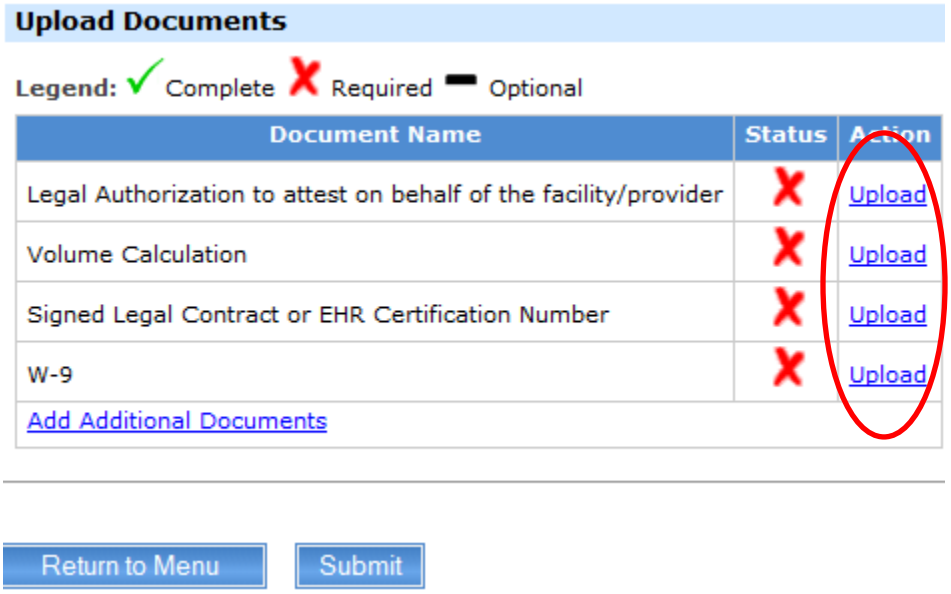
7. Required Documents to Upload

   ➔ ✗ indicates the document is required

   ➔ ▬ indicates the document is optional and can be uploaded

   ➔ ✓ indicates the document has been uploaded successfully

   If any additional documents need to be updated to provide any explanations or assist with verification, select the Add Additional Documents link. The more verifying documents uploaded will help speed up the verification and payment process.



   7.1. Legal Authorization to attest ➔ Must be a current dated letter from the CEO/CIO of the facility granting permission to the person attesting on behalf of the facility

   7.2. Volume Calculation ➔ **MUST** Use the calculation Template located at: http://www.healthit.nd.gov/medicaid/

   7.3. Signed Legal Contract ➔ Legal binding contract of the EHR system used at the facility

   7.4. W-9 ➔ Current W-9 to whom the payment is being made (usually the facility)

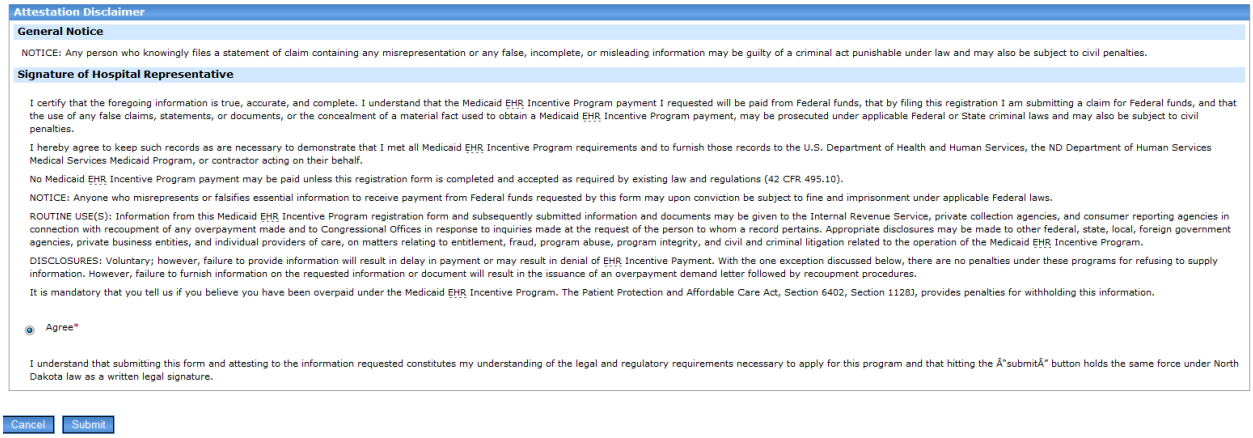
   7.5. MU Dashboard ➔ If attesting to MU, the Core, Menu, and CQM dashboard from the EHR must be provided to verify the MU data

8. If complete, select "Submit" to complete the Attestation.

9. The user must agree to the terms/disclaimer

   All documentation for each attestation must be kept for a minimum of six (6) years and the attestation can be subject to audit for up to six (6) years. If the documentation cannot be provided,

the payment will be recouped.



Attestation Disclaimer

General Notice

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may also be subject to civil penalties.

Signature of Hospital Representative

I certify that the foregoing information is true, accurate, and complete. I understand that the Medicaid EHR Incentive Program payment I requested will be paid from Federal funds, that by filing this registration I am submitting a claim for Federal funds, and that the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain a Medicaid EHR Incentive Program payment, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.

I hereby agree to keep such records as are necessary to demonstrate that I met all Medicaid EHR Incentive Program requirements and to furnish those records to the U.S. Department of Health and Human Services, the ND Department of Human Services Medical Services Medicaid Program, or contractor acting on their behalf.

No Medicaid EHR Incentive Program payment may be paid unless this registration form is completed and accepted as required by existing law and regulations (42 CFR 495.10).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

ROUTINE USE(S): Information from this Medicaid EHR Incentive Program registration form and subsequently submitted information and documents may be given to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment of any overpayment made and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the Medicaid EHR Incentive Program.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of EHR Incentive Payment. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information on the requested information or document will result in the issuance of an overpayment demand letter followed by recoupment procedures.

It is mandatory that you tell us if you believe you have been overpaid under the Medicaid EHR Incentive Program. The Patient Protection and Affordable Care Act, Section 6402, Section 1128J, provides penalties for withholding this information.

Agree*

I understand that submitting this form and attesting to the information requested constitutes my understanding of the legal and regulatory requirements necessary to apply for this program and that hitting the Â"submitÂ" button holds the same force under North Dakota law as a written legal signature.

Cancel Submit